AAPM&R Membership Application

Associate (Completed Training in a PM&R Residency Program)

First Name (PLEASE PRINT) | M. I. | Last Name | Degree(s)

BUSINESS ADDRESS* ○ Preferred Mailing ○ Preferred Billing

Title

Institution

Department/Room/Suite

Street

City, State, Zip

Country

Telephone

Fax

Business Email Address ○ Primary Email

Website URL

HOME ADDRESS ○ Preferred Mailing ○ Preferred Billing

Street/Apt

City, State, Zip

Country

Telephone ○ Mobile Phone

Fax

Home Email Address ○ Primary Email

Referring Member (IF APPLICABLE)

*Your business address will be used for the Member Directory. The *PM&R* journal and *The Physiatrist* will be sent to your preferred mailing address, and dues renewal notices to your preferred billing address. All Academy email communications will be sent to your primary email address.

PERSONAL AND PROFESSIONAL INFORMATION

Date of Birth (MM/DD/YY) Gender: ○ Male ○ Female ○ Non-Binary

Do you consider yourself to be a gender or sexual minority? ○ Yes ○ No

Do you consent to allow AAPM&R to store and process your ethnicity information? ○ Yes ○ No

The Academy is committed to the principle of diversity in its membership and leadership. Accordingly, applicants are invited to indicate which one of the following may best describe them (check all that apply):

☐ Black or African American (Africa, West Indian, Caribbean) ☐ Asian (Far East, Southeast Asia, Indian)
☐ American Indian or Alaska Native (North America, South America, Central America) ☐ White (Europe, Middle East, North Africa)
☐ Hispanic (of any race) ☐ Native Hawaiian or Other Pacific Islander (Hawaii, Guam, Samoa, Pacific Islands)

Do you consider yourself to have a disability as defined by the Americans with Disabilities Act? ○ Yes ○ No

Primary Language Spoken

Academic Degrees Conferred by Date (MONTH/YEAR)

Medical Degrees Conferred by Date (MONTH/YEAR)

PM&R Residency: Institution Graduation (MONTH/YEAR)

Licensed in the state of Year Number

NPI Number Opioid Prescriber Number

MEMBERSHIP TYPE

☐ I am applying for **ASSOCIATE MEMBERSHIP IN THE ACADEMY**. I have completed training in an approved PM&R residency program.

☐ I have passed Part I of the ABPMR, dated (MONTH) , (YEAR) (if applicable).

CONTINUED ON BACK »

MEMBER COMMUNITIES

MEMBER COMMUNITIES are self-identified, organically established communities offering opportunities for members of all different backgrounds to connect with each other, share experiences, collaborate, and advance the future of the specialty together!

- ☐ Adaptive Athletes and Sports
- ☐ African American Physiatrists
- ☐ Alternative Pain Medicine
- ☐ Amputee/Limb Loss Restoration Rehabilitation
- ☐ Asian Physiatrists
- ☐ Brain Injury Medicine Current Fellows and Future Candidates
- ☐ Business of Healthcare Physiatrists
- ☐ Cancer Rehabilitation Medicine
- ☐ Central Nervous System (CNS)
- ☐ Chicago Physiatrists
- ☐ Early-Career Physiatrists
- ☐ Exercise as Medicine
- ☐ Geriatric Rehabilitation
- ☐ Hypermobility Syndrome
- ☐ Inpatient Consultants
- ☐ Inpatient Rehabilitation
- ☐ Intellectual Disability
- ☐ International Rehabilitation and Global Health
- ☐ Interventional Pain
- ☐ Introverted Leaders
- ☐ Kosher Physiatry
- ☐ LatinX in Physiatry
- ☐ LGBTQIA+ in Physiatry
- ☐ Medical Educators
- ☐ Muslim Physiatrists
- ☐ Neuromodulation
- ☐ Neuromuscular Medicine and EDX
- ☐ Overhead Athlete
- ☐ Pain Medicine
- ☐ Pediatric Rehabilitation Medicine
- ☐ Pediatric Rehabilitation Medicine Current Fellows/Combination Residents and Future Candidates
- ☐ Pediatric Sports Medicine
- ☐ Performing Arts Medicine
- ☐ Physiatry in Skilled Nursing Facilities
- ☐ Physiatry Life Care Planners
- ☐ Private Practice Physiatrists
- ☐ Puerto Rican Physiatrists
- ☐ Regenerative Medicine
- ☐ Research in Physiatry
- ☐ Running Medicine
- ☐ South Asian Physiatrists
- ☐ Spine Medicine
- ☐ Sports Medicine
- ☐ Sports Medicine Current Fellows and Future Candidates
- ☐ Texas Physiatrists
- ☐ Women Physiatrists
- ☐ Wound Medicine

HOW DID YOU HEAR ABOUT US?

☐ Colleague ☐ AAPM&R Website ☐ Residency Director ☐ AAPM&R Email Communications ☐ Mentor

☐ Other (please specify) _____

SIGNATURE OF APPLICANT

If I am accepted for membership in the American Academy of Physical Medicine and Rehabilitation I agree to support its bylaws and to practice in accordance with the established principles of the American Medical Association.

_____ _____

Signature of Applicant Date

If you are a resident of the European Union and/or United Kingdom, please review our privacy policy at http://www.aapmr.org/privacy-policy/privacy-policy-eu-uk

PAYMENT INFORMATION

MEMBER TYPE & FEES

Associate Member

○ 2023 Calendar Year Membership $750 (USD)

REMIT PAYMENT AND FORMS

MAIL TO: American Academy of Physical Medicine and Rehabilitation
P.O. Box 95528
Chicago, IL 60694-5528
**Please do not send payments to the national office.*

FAX TO: (847) 563-4191
Faxed applications must include CREDIT CARD PAYMENT information.

QUESTIONS? Email us at memberservices@aapmr.org.

FORM OF PAYMENT

☐ Check # _____ Made payable to AAPM&R

☐ Credit Card

○ MasterCard ○ VISA ○ Discover ○ American Express

Expiration Date ____ / ____ CVV ____

_____

Credit Card Number

_____

Cardholder's Name (PLEASE PRINT NAME AS IT APPEARS ON CARD)

_____

Signature (CREDIT CARD PAYMENTS ONLY)

THANK YOU!

Thank you for your interest in joining the American Academy of Physical Medicine and Rehabilitation (AAPM&R). For more information on member benefits and to learn more about the organization, please visit: www.aapmr.org.

aapm&r
American Academy of Physical Medicine and Rehabilitation

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